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### **Medication Administration Agreement Procedure**

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**PURPOSE:** To ensure the Managing Employer understands and agrees to the terms and conditions of the Agency with Choice Medication Administration Agreement (EMAA).

**Declines Medication Administration:** The Managing Employer will decide if the Self-Directed Employee (SDE) will be administering medication to the consumer as part of the SDE's job responsibilities. If the Managing Employer decides no medication will be administered by the SDE, the Managing Employer will select and signoff on one of the following:

- The consumer does not take medication.
- The consumer will not be taking medication during the time of the SDE's shift.
- The Managing Employer will administer all of the consumer's medications.

**Medication Administration:** If the Managing Employer requires the SDE to administer medications as part of the SDE's job responsibilities, the Managing Employer must agree to the terms and condition in the EMAA. If the Managing Employer does not agree to all the terms and conditions of the EMAA, then the SDE will not be authorized to administer medication to the consumer.

If the SDE had not been administering medication as part of his/hers job responsibilities, but the Managing Employer now requires the SDE to administer medication, the Managing Employer must now agree to the terms and conditions in the EMAA. If the Managing Employer does not agree to all the terms and conditions of the EMAA, then the SDE will not be authorized to administer medication to the service recipient.

No SDE will administer any medication until they have completed and passed the College of Direct Support Medication Trainings and Medication Practicum (the on-site competency assessment).

- The Managing Employer will conduct the On-Site Competency Assessment
- The Health and Medication History form must be completed as a requirement of the SDE Medication Administration and reviewed as part of the On-Site Competency Assessment.

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### **Agency with Choice Medication Administration Agreement**

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Self-Directed Employees (SDE) may administer medications to a service recipient in his/her care. The SDE must complete and pass all the DDD College of Direct Support Medication Trainings, Medication Practicum and review the service recipient's Health and Medication History.

1. Medication Basics
2. Working with Medications
3. Administration of Medications and Treatment
4. Follow-up Communication and Documentation of Medications
5. Medication Practicum (On-Site Competency Assessment)
6. Health and Medication History Form

NO SELF-DIRECTED EMPLOYEE MAY ADMINISTER **ANY** \*MEDICATION, UNLESS THEY HAVE PASSED ALL PHASES OF THE COLLEGE OF DIRECT SUPPORT MEDICATION TRAINING AND MEDICATION PRACTICUM.

\*Medication includes but not limited to prescription medications, over the counter medications (headache, cough, eye drops, etc.), emergency medications (epi pen, nitroglycerin, inhaler for asthma, etc.) vitamins, supplements, creams/ointments, etc.

The service recipient, family member/guardian must adhere to the following:

**General Requirements:**

- Complete and review the Health and Medication History Form with SDE.
- Observe the SDE administer medication as part of the Medication Practicum and complete the New Jersey Division of Developmental Disabilities Medication Administration Evaluation Form.
- If possible, obtain copies of prescriptions for medications to be administered by the SDE.
- The information on the prescription and the pharmacy label must match.
- Medications must be current, must have most current prescription.
- For each medication the SDE administers, he/she shall have a copy of the medication information insert that was included when the medication was filled.
- The service recipient's medications must be stored in a box/container/baggie that is separate from the other members of the household's medication.
- Medications must be stored in a secure place out of the reach of possible consumption, but accessible to the SDE.
- Medications will be administered as prescribed. Medications cannot be altered, crushed, hidden in food, diluted, etc., unless written on a prescription or a physician's note.
- Only one person, either the SDE or the family member/guardian, will administer the medication during the SDE's shift.
- Upon arrival the SDE will check to ensure all medications and supplies are available to administer medications. If they are not, the SDE will not be able to provide services until all the medications and supplies are available.

**Prescription Medications:**

Prescription medications must be in the original labeled pharmacy container and contain the following:

- First and last name of the service recipient
- Date medication was ordered/date it was filled
- Name of medication
- Type of medication
- The dosage
- Times for administration (specific time or number of times to be taken)
- Correct administration route and
- Special administration or storage instructions, if necessary

**Over-the-Counter medications:** These are medications that normally don't require a prescription. Some over-the-counter medications are used every day, like vitamins, nutritional drinks etc. Other over-the-counter medications are taken when the person is not feeling well, like an antacid for upset stomach, cough syrup or ointment for a rash.

Over-the-counter medications **WILL** require a prescription or a physician's note, and a label to affix to the medication, vitamins, or supplements which must include:

- First and last name of the service recipient

**Financial Management Services Procedure No.:**  
**Areas Affected: AwC**

**Effective Date: 6/15/2019**  
**Revised Date: 10/01/2020**  
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- Date medication was ordered/date it was filled
- Name of the medication/vitamin/supplement
- The dosage
- **The specified time interval between dosage**
- **The maximum amount to be given in a 24-hour period**
- **The condition under which the medication shall be administered and a stop date.**

**PRN medication (as needed),**

PRN medications, prescription or over-the-counter medication **WILL** require a prescription or a physician's note which must include:

- First and last name of the service recipient
- Date medication was ordered/date it was filled
- Name of the medication/vitamin/supplement
- The dosage
- **The specified time interval between dosage**
- **The maximum amount to be given in a 24-hour period**
- **The condition under which the medication shall be administered and a stop date.**

I, \_\_\_\_\_ (name of Managing Employer) understand and agree with the terms and conditions in Agency with Choice Medication Administration Agreement. I understand that if I fail to follow the requirements, the SDE may not administer medication to the service recipient and could jeopardize the service recipient's health and/or the SDE's employment for the service recipient.

\_\_\_\_\_  
Please Print Name of Managing Employer

\_\_\_\_\_  
Name of Consumer

\_\_\_\_\_  
Signature of Managing Employer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Self-Directed Employee, Please Print Name

\_\_\_\_\_  
SDE Signature

\_\_\_\_\_  
Date

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### Health and Medication History Procedure

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PURPOSE: To ensure Self Directed Employees (SDE) have access to the consumer's health and medication history as part of the Self-Directed medication administration.

1. The Health and Medication History form, although not mandatory, will be asked to be filled out for each consumer.
2. The Health and Medication History form **must** be completed as a requirement of Self-Directed Employee's Medication Administration.
3. The Health and Medication History form is to be completed, signed by Managing Employer and reviewed as part of the SDE Medication Practicum (the on-site competency assessment).
4. The Health and Medication History form shall be updated by the Managing Employer whenever there is a change in the consumer's health history or medication.

# Health and Medication History

Directions: This form **must** be completed, as per the Medication Administration Agreement, prior to any Self-Directed Employee (SDE) giving medication. In such situations, a copy of this form must always be available to the SDE (consumer and/or authorized representative to determine exact location within the work site). This form must be updated whenever changes are made, or at a minimum, once per year.

If the SDE is not giving medication, the medical history is still requested in case of emergency.

<b>Consumer Information:</b> Complete each area of this section									
Name:		Date of Birth:		Gender:		Height:		Weight:	
Address				City:			State:		ZIP:
Home Phone:			Cell Phone:			Email:			

<b>Emergency Contact:</b> Complete all information. By providing this information, you are authorizing release of medical information to this person									
Name:		Address:			City:			State:	ZIP:
Home Phone:			Cell Phone:			Email:			
Relationship: _____ Care Provider _____ Parent _____ Sibling _____ Other:									

<b>Guardianship Information</b>									
Do you have a legally appointed guardian, medical conservator, or who has durable power of attorney? _____ Yes _____ No									
<i>If yes, please complete the information below:</i>									
Name:		Address:			City:			State:	ZIP:
Home Phone:			Cell Phone:			Email:			

# Health and Medication History

<b>Allergies:</b>		
Do you have any allergies? (Include foods, medications, environment, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes, please complete the information below:</i>		
Allergic to what?	What was the reaction?	Did you seek medical treatment?
1.		
2.		
3.		
4.		

<b>Medical Care Providers:</b>			
Hospital of preference:			
Primary Doctor Name:		Primary Doctor Phone:	
Does the consumer see any specialists? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If yes, please complete the information below:</i>			
Specialty	Name		Phone
1.			
2.			
3.			
Insurance Company:		Policy Number:	

## Health and Medication History

Medicaid Number		Medicare Number:	
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### Medical History Questionnaire:

Are you on a special diet?	_____ Yes _____ No
If yes, what are your dietary restrictions? _____	
Do you have any history of organ issues or malfunction?	_____ Yes _____ No
If yes, what organ(s): _____ Heart _____ Liver _____ Lung _____ Kidney _____ Bowels _____ Other	
Please explain:	
Do you have any chronic conditions?	_____ Yes _____ No
If yes, what: _____ Seizure disorder _____ Diabetes _____ Arthritis _____ High Blood Pressure _____ Low Blood Pressure _____ Other	
Please explain:	
Is there any other pertinent medical information that your caretakers/SDE should know? If yes, please note it here:	
Do you take any medications (prescription, OTC, or supplements)?	_____ Yes _____ No
If yes, check which applies: _____ SDE will be administering medications _____ Medications administered by family/guardian _____ Medication not needed during SDE's shift _____ Individual will self-administer medications	

## Health and Medication History

**If medication administration is approved as a service provided, complete the medication information on the following pages in addition to the Medication Administration Agreement form, which must be returned to Easterseals NJ**

<b>Medication History: List ALL current prescription medications:</b>				
Name of Medication	How much do you take? <i>Ex. 5 mg tablet</i>	When do you take it?	Why do you take it?	Do you have any problems or concerns with this medication?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

<b>Medication History: List ALL Over-the-Counter Medications, Supplements, Herbal remedies, etc.</b>				
Name of Medication	How much do you take?	When was the last time you took it?	Why do you take it?	Do you have any problems or concerns with this medication?
1.				
2.				
3.				



# Health and Medication History

4.				
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